Specialist services in the community: a qualitative study of consultants holding novel types of employment contracts in England

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ABSTRACT

The aim of this study was to understand, from consultants' experiences, the potential benefits and limitations of specialists being employed by a community organisation. We carried out a qualitative study using semi-structured interviews with consultants holding novel contracts across three specialties: geriatric, respiratory and palliative medicine. Consultants in our study reported that community-based roles offered a number of potential benefits. They felt better able to take a population perspective, to treat patients in a holistic sense and to form good working relationships with community-based colleagues. A number of challenges were also evident, including a lack of clarity about their role, professional isolation and, for those in geriatric and respiratory medicine, a lack of training and career development opportunities. Our study suggests that community-based consultant posts are often taken up by highly motivated individuals who report the benefits in terms of being able to provide more appropriate care for patients but that the long-term development of these posts may be constrained by a number of factors. Their idiosyncratic nature, the lack of clarity around the role, challenges to professional identity and lack of training opportunities or professional development suggest that current approaches to their development may not be sustainable.

KEYWORDS: Specialist services, consultants, community-based care, qualitative

Introduction

There are strong policy and service drivers in England to prevent avoidable hospital referrals and admissions, and treat people closer to home.[1] In England, specialists traditionally work in hospitals for both inpatient and outpatient work and are employed by hospitals (called 'acute trusts' in the English NHS). Traditional attempts to relocate specialist services in the community and reduce demand for hospital outpatients have included shifted outpatient clinics and attachment of specialists to primary care teams. Evidence suggests that such arrangements can improve access to care but that impact on hospital use and health outcomes is less clear.[2–4] In the case of specialist attachment to primary care teams, few evaluations have been reported but evidence suggests that they may be costly and depend greatly on the enthusiasm of individual specialists.[5,6] One of the limitations with the traditional means of relocation of secondary care to primary care is that specialists have, in general, remained employed by acute trusts and as such may have little real incentive to reduce referrals. In practice they have become drawn back into hospital work, reducing the extent to which they develop new means of working with primary, secondary and social care providers to improve care pathways.[7]

There are an increasing number of novel arrangements for consultants in England, whereby consultants are contracted solely or for the majority of their time by a community trust. To our knowledge such arrangements have not been the subject of previous research, and the extent to which consultants are working in these ways and the impact of these contractual arrangements may have on patient care, the consultants themselves and the wider workforce are not well understood. Given this lack of research, this study aimed to understand the potential benefits and limitations of these new contractual arrangements, focusing on the perceptions and experiences of community-employed consultants rather than to measure their effectiveness. Increasing understanding in this area may provide important learning, particularly at a time of financial pressures to reduce referrals and increased focus of health services on community-based care and integrated care.[8]

Methods

A qualitative approach using semi-structured interviews was adopted, with interviews conducted between November 2013 and May 2014.

We focused on specialties that have to date been largely hospital-based specialties in England. There is no routine source from which to identify consultants who hold at least

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part of their contract with a community organisation, either as direct employees or through sub-contracts from an acute trust, which were our primary eligibility criteria. Hence, we used opportunistic sampling to identify individual consultants and snowballed from there, asking participants to suggest other potentially eligible consultants. This led to an initial focus on geriatric and respiratory medicine. We then deliberately sought palliative medicine as a third specialty, anticipating that there would be sufficient numbers of consultants in palliative medicine with a community-based contract to see whether themes arising from the initial interviews would apply to another specialty. These consultants were recruited by means of an advert placed in the Association of Palliative Medicine newsletter. Within our sampling, we attempted to ensure a range of participants according to employer organisation, geographic setting and stage of consultant career. At point of interview, participants were asked to confirm that they held at least part of their contract with a community organisation. Systematic data on the number of sessions delivered under these contracts were not collected, rather participants were asked to describe different aspects of their jobs in their own words.

The purpose of the study was explained to all potential participants at point of first contact and again before commencing the interview. Verbal consent was sought to participate and to audio-record the interview. Interviews were typically conducted by phone. A common interview guide was used in each interview, although emphasis was given to allowing participants to talk from their own perspective. Driven by the research aims, questions were designed to understand the nature of the role, what works well or less well with the post, experience of working with colleagues in the community and acute trust, and training and recruitment. Interviews were transcribed *verbatim* and names of participants removed. In two cases where it was not possible to audio record the interviews full notes were taken.

Data collection and analysis were an iterative process as findings from initial interviews informed sampling and themes to be explored in subsequent interviews. Analysis was led by one researcher (EP) but discussed frequently between EP and MR throughout. Analysis was informed to some extent by the research questions but largely an inductive approach was taken to look for themes emerging from the data. As part of a systematic process based on the constant comparative method,[9] transcripts were read and re-read and 'codes' applied to meaningful sections of texts without any initial attempt to impose a framework. As analysis progressed these were organised into overarching or organising themes which were modified and checked as analysis proceeded. The qualitative software Nvivo10 was used to support the analysis. As agreed, we checked the use of quotations with participants before publishing these findings. Quotations are presented with participant number and clinical specialty (GM = geriatric medicine; PM = palliative medicine; RM = respiratory medicine).

Based on advice from the National Research Ethics Service and Cambridgeshire Local Research Ethics Committee, the study was deemed service evaluation and we did not obtain formal ethics approval, but sought to adhere to good research ethics practice throughout.

Results

We completed 14 interviews, 12 of which were audio recorded (all but Int01, Int10). All participants were consultants (full or part time), seven working in geriatrics, three in respiratory medicine and four in palliative medicine. Employment arrangements varied by individual and in many instances had undergone different iterations with changes in community organisations over time. With the exception of participants working in palliative medicine, participants had previously been employed by an acute trust. We were not able to recruit any newly qualified consultants who were employed by a community trust in their first consultant post. In general the interviews were a very rich source of information. Consultants were eager and willing to talk about their experiences, reflecting their commitment to community posts, challenges encountered and concerns for sustainability. A number of themes arose in the analysis which we outline below.

Origin and development of posts

A clear theme was the importance of individual commitment and motivation to both creating and shaping posts which were often largely unspecified at outset. For most of the consultants we spoke to, the motivation reported for taking up a community-held contract was part of a wider vision that more community management would better meet the needs of patients and a view that a population perspective was preferable to a disease or condition focus that they felt was more prevalent in acute care.

> *For a number of years we'd been developing the community service…and that's what my interest was, the repetitive and, I felt, rather fruitless nature of acute care, we don't actually fix anything. The patients just come back again and again and again because you never actually address the underlying issues and you patch them up and you send them out with very little result Also, a lot of patients you get admitted, you think, 'Well, had I known about this patient six months ago, I would have done something so they wouldn't be here now', and so the Trust over the last ten years has been developing community service to meet those needs of frail, older people and having set up the services to supply them, I was then able to transfer my contract across in order to provide the consultant leadership and medical specialist input to those services. (*GM 08)

This said, in addition to the motivation of consultants who created the posts, what they wanted had to fit with the agenda of the organisations with whom they were negotiating. In the case of several geriatricians, the creation of posts was only agreed when community trusts calculated that it was financially preferable to directly employ consultants in community roles, rather than paying the capitation fees associated with acute trust employees providing community sessions. Other examples from respiratory medicine were where trusts were particularly committed to a larger vision of integrated care and creating new pathways for patients.

> *It's got to be part of the organisation agenda it can't just be, you can't be individual people kind of swimming against the tide… yes I think it's all about whichever organisation it is, investing in this is the right way to do things and supporting it.* (GM 04)

Table 1. Community consultant roles: overview of main areas of responsibility.

Area of responsibility	Description of role	Examples of implementation
Clinical	Clinical responsibility for own caseload or managing others with caseload	> In-reach ward rounds > Outpatient/community clinics (single specialty or joint with other specialties) > Domiciliary visits > Hotline service for patients > Supporting nurse specialists holding caseload > Multidisciplinary team meetings/complex case reviews
Strategic	Developing pathways or models of care	> Development of patient pathways > Improving working practices between GPs and nursing homes > Developing strategic partnerships, for example, across specialties or with third sector
Educational	> Educating GP and wider community-based workforce in what community consultant can do > Providing specialty-specific education to GPs and others to improve management in primary care.	> Visiting individual GP practices > COPD/condition-specific review of diagnoses and management in GP practices

COPD = chronic obstructive pulmonary disease; GP = general practitioner.

It was similarly evident that consultants had a lot of scope in shaping and developing individual posts once created; often speaking of the notion of starting 'with a blank sheet of paper'.

> *Well when I first started I had this sort of, I had a telephone and blank diary, that's how much they knew what to do with me. No induction, no thinking, nothing in the diary, just that was it.* (PM 14)

> *I think that just depends on your attitude really. My experience is that when I first came I wasn't at all busy because nobody quite knew how to use me as you rightly say and now I'm incredibly busy 'cause you do literally have to go looking for work.* (GM 02)

Although consultants described having free rein to develop their posts, the main components of posts, developed over time, were similar for consultants across the three specialties: clinical, strategic and educational. These are shown in more detail in Table 1.

A number of consultants reflected that the lack of specification for their roles was potentially liberating and that they could often achieve a lot without the organisational constraints that might normally be present.

> *I had nobody bearing down on you saying, I need you to do this by next week, or you know, you're accountable for that, nobody had a clue, so I just did what everybody's obviously very pleased with now, so it was, in a way, it was completely unsupported and on the other hand totally free, and the pressure came from within ourselves to do a good job.* (PM 14)

Significance of where contract was held

Some interviewees reflected that it did not matter where their contract was held, '*Who holds your contract is much less relevant than the job that you do*' (GM 02) but for others it made a key difference. One consultant was able to directly compare being a community geriatrician contracted to an acute trust with being contracted to a community organisation and the fundamental difference in these roles.

> *I think at that time [when contracted to acute trust] I would say, one still felt like a hospital doctor because one was based at the hospital and did all the same tasks and roles that all the other hospital consultants were doing so it was really like a sessional commitment to the community work, if you like.…it's [the new post with the community trust] not just about turning up and doing a service, a lot of it is about changing culture, up-skilling people, you know, looking at attitudes and the belief statures in community workers, the rehab teams, the nurses, the GPs.* (GM 06)

The tension that could be created as a result of where contracts were held was further evident where consultants were still employed by an acute trust but subcontracted to a community trust.

> *So the main problem is that you're working for two diametrically opposed trusts. So on the one hand what I'm doing is keeping people out of the acute trusts as much as I can and if you… I was given a free rein I could really, you know, decimate their income. Whereas, on the other hand I actually am fully employed, my contract is held by the acute trust and they're telling me all the time to be mindful that I actually work for them. And that I have to be careful that I don't, sort of, disrupt the apple cart too much, that I don't want to take away too much work.* (RM 09)

Centrality of relationships and understanding of role

As noted, consultants described that an important part of their role was in educating general practitioners (GPs) and the wider community workforce. It was clear from the interviews that forming good relationships, particularly with GPs, was central

to the success of the community consultant role and could be one of the more challenging and rewarding aspects of the role. In doing this the right balance had to be sought in supporting GPs and ensuring they were aware of what a community consultant could offer but at the same time, being careful not to cross professional boundaries.

> *I really regard myself and my service as a supplementary service, it's a, sort of, complimentary service to general practice, it's not parallel and we mustn't be seen…we mustn't, A) be seen to set up a parallel service to primary care because we need primary care to make it work and B) if it's…there isn't enough of capacity in community geriatrics to do primary care as well.* (GM 03)

> *I think it's working alongside your referrers, understanding what they need from you, understanding their challenges, their constraints and valuing their skills very much. Certainly, in the community, you have very skilled GPs and it's understanding their skills. They don't want people to come and take over, they want people to help and support them and skill them and help them with the complex cases and I think it's about building up those relationships.* (PM 11)

Consultants reported a range of different strategies that they might adopt to try and build such relationships including regular visits to GPs, providing GPs with their own mobile number and using opportunities such as national initiatives or changes in guidelines to build educational events for colleagues in primary care. These strategies were generally adopted and adapted over time by individual consultants, although one reported that their local clinical commissioning group had instigated a pairing scheme between consultants and GPs that was a useful forum to build relationships and plan more proactively and strategically.

For some, relationships with hospital-based colleagues were as important but also challenging. Among the consultants in geriatric and respiratory medicine that we spoke to, there was a perception often of a 'them and us' mentality and a perceived lack of understanding among hospital-based colleagues of what community-based consultants could do and also, in some cases, that community consultants were not accorded the same status.

> *Community is like being…they would say it's like being a GP. They feel perhaps that you're not a proper…it doesn't have the buzz and the adrenaline and the status of being a secondary care doctor, I think but I think that's got to change because in actual fact I think that what I do is far more influential than what they do now.* (RM 09)

Consultants often reported that relationships with the acute trust were helped when they had previously worked for the trust or where they knew colleagues well. These consultants often made deliberate efforts to interact with hospital-based colleagues to maintain these links though it was considered more challenging for new consultants.

The perceived gap between community and acute services was reported to a far lesser extent among the palliative care consultants we spoke to, perhaps because palliative medicine has traditionally had closer relationships with community-based services. In some cases very close working relationships were reported with hospital-based colleagues.

Potential professional isolation

A common theme across the three specialties was that community consultant roles could be potentially isolating; the relative freedom to work on one's own and shape the role was countered by feelings of professional isolation.

> *It's quite [an] isolated job and isolating. It's very much I think you have to be quite self-contained because actually I'm pretty much on my own. So there are no other doctors as such around me which can be tough sometimes.* (GM 03)

> *You know, I was lonely. I had another colleague who was working the other end of the patch and we obviously used to see each other, but I didn't have that buzz of having lots of people around. I'm surprised at that, that was one of the challenges, I think, to be a bit more isolated.* (GM 07)

Particular difficulties that consultants faced was not having a similar colleague close by with whom they could check decisions, the opportunity to attend educational meetings regularly and, for some, the 'buzz' associated with working in a specialist team. However, interestingly one consultant (GM 06) reflected at having established relationships within the community that provided a more stable and closer team than she thought could be achieved in a hospital setting. The degree to which consultants felt isolated varied but a common idea coming from the interviews was that 'resilience' was a key characteristic needed in the role. Most of the strategies adopted to try and mitigate isolation were individually driven. For example, consultants would arrange to meet regularly with colleagues in neighbouring areas or in acute trusts, would identify educational opportunities, or seek to do some on-call duties to keep them in touch with consultant colleagues. In some cases these arrangements had become more formalised over time where community teams had become established. Often consultants would go to considerable lengths to travel to meetings because of the benefit and interaction that it brought.

> *I could probably get [the substance of the meeting] from somebody else telling me in 10 minutes, but actually I go because other consultant colleagues go, which is a bit sad, essentially it's my only opportunity in a week to hopefully, they'll be somebody else there, and I might just speak to them for well, one or two minutes but at least you're hearing what other people are saying about various clinical situations, you're kind of making sure that you're staying up to date, and you know, having the same challenges* (PM 14)

In one case, the potentially isolating nature of the community consultant role had partly contributed to a decision to move the main contract of employment from a community trust to the acute trust so that more support was available.

Training, preparedness and sustainability

In trying to understand how the skill and training requirements of community-based consultants might differ from those needed in more traditional hospital-based roles, participants consistently identified three things that were perhaps not unique to community roles but areas where greater emphasis was needed. These were i) having a greater acceptance of and ability to manage risk, as access to investigations is often

Table 2. Key skills identified for community-based consultants.

Skills areas	Quotation (interview ID)
Acceptance and management of risk	*…you're having to accept that you're taking greater risks in some ways. And also I think it's almost going back to your basics, your clinical skills cause that's what you rely on. Because you can't always get everything else around you to say well actually it's not x, y and z. Which might not be a bad thing but it's a different way of working…* (GM 03)
Teamwork	*Communication is a huge one, managing a team is another big one, you know, being able to work well within a team environment and being able to trust your other team members is absolutely key…* (RM 09)
Holistic management of patients at home	*…the biggest point of learning is to think much more broadly than simple medicine. So it's dealing with the whole psychosocial components of a presentation because in frail older people living in the community simply fixing the medicine doesn't solve their issues, doesn't solve the problem, more broad base problem solving approach, than you would traditionally get in acute medicine, so it's much more challenging. That's what makes it interesting…* (GM 08)
	And I have a much better insight into you know how difficult it is assessing somebody at home sometimes. You know you've got the dog or you've got whatever and trying to examine abdomens, it's very hard at home. Yes all of those things is very difficult… (GM 03)

limited; ii) having the ability to build and work effectively in diverse teams covering specialty care, primary care, social services and others; and iii) managing a patient holistically, often in their home, rather than by nature of their diagnosis (Table 2).

Of the three specialties we covered, palliative medicine training routinely involves a community-based component and it was evident from the interviews that consultants in palliative medicine generally felt better prepared for work as a community consultant than the consultants in geriatrics and respiratory medicine.

> *I think I did feel prepared to work in a community post because of the experience that I've had. So, you know, when I started I was already very clear how I would work, how I would write to GPs…how it would all be set up. So I think that felt a very easy transition* (PM 13)

Despite this, challenges remained in maintaining training positions in community organisations for palliative care, particularly in a financial climate where trusts had to make efficiency savings. The other two specialties however seemed to face more fundamental challenges to creating training posts and in attracting high-quality candidates. In some cases it had been possible to set up a purely community-based training opportunity, however in others, consultants were reliant on trainees choosing to spend some of their training in the community which could depend on their acute trust releasing them. One of the challenges that participants thought was preventing more interest in community-based posts was the perception of low status of community-based consultants within the professions.

> *So one of the other main challenges that you have of course, is overcoming the perception that community care or integrated care is a Cinderella-type specialty, sort of, a bit tree huggy and a bit, you know, this isn't really respiratory medicine it's all primary care type nonsense. In the past there has been a deception that the people that do these sort of roles are the ones that can't get a proper job.* (RM 09)

The consultants we spoke to were clear that where there was a lack of training opportunities this had a knock-on effect on recruitment and raised real concerns about the sustainability of community-based posts, even in areas where there was good support for the posts and where they were highly valued.

> *It's a huge, huge problem for us and when my colleagues in [neighbouring area] wanted to recruit some similar sorts of post to do the same thing for their service…they advertised several times with no success at all…So we have tempered our expectations and are trying to advertise posts sort of half and half, with limited success…So they're [trainees] comfortable in the hospital, they feel that's what their training has provided them with and they don't know what to do in the community.* (GM 08)

Discussion

Directly employing or subcontracting consultants to community organisations offers, in theory, a number of potential benefits over more traditional means of relocating specialist services in the community. Our exploratory study showed that consultants believed that such working arrangements offered greater potential to take a population perspective, to treat patients in a holistic sense and to form good working relationships with GPs and other community-based colleagues to improve care for patients. However, our findings also highlight a number of challenges to these new models of working. Community consultant posts are often idiosyncratic. Consultants, particularly within geriatrics, reported that they had often taken forward the vision to create their own post and were responsible for shaping their post. While this offered flexibility and a certain degree of freedom that consultants welcomed, the lack of clarity regarding roles clearly presented challenges. Consultants could feel isolated as it took time for community-based professionals to work out how to work with them, while at the same time they experienced isolation from hospital-based colleagues. Concerns were also raised around the longer term development and sustainability of community-based posts because of the lack of training opportunities or recognition of such posts within career development opportunities. The experience of consultants in palliative medicine, in contrast to those in geriatric and respiratory medicine, was that a community-based component within their specialist training prepared them well for

the requirements of community-based posts and added legitimacy to their career choice.

In literature drawing on sociology of the professions, issues of identity and negotiation of boundaries has highlighted some of the challenges with previous policies around workforce modernisation in the NHS in England.[10,11] In terms of increasing specialist provision of care in the community these have typically provided for role expansion through vertical substitution of tasks,[12] for example, through GPs with specialist interests or specialist nurses.[10,13,14] These studies suggest that inter- and intra-professional boundaries may be particularly important to understand, and that reconfiguration of professional roles may be limited or slow to take place in the NHS if professional identity is threatened too strongly and the development of new roles is not supported institutionally, for example by professional bodies.[10] In our case, the concern was less to do with vertical substitution but 'diversification' within selected specialties, as consultants with community-held contracts represent a novel approach to practice, providing services in new ways and in a different setting.[12] Contrary to more traditional models of relocating specialist services, consultants in our sample did seem to feel that they had developed new ways to collaborate with GPs which acknowledged their expertise, and that they were not looking to merely extend a model of hospital care in a community setting.[12,15,16] This said, our findings suggest that issues around professional identity may also be important and that inter- and intra-professional, including intra-specialty, relationships may be crucial to understand. Previous research has highlighted the perceived status and superiority gap between generalists and specialists within the community, but in the context of community-based contracts, our findings suggest that this gap may be equally significant between hospital and community-based specialists.[15] Similar to the studies of the early introduction of nurse specialists, our interviews showed that consultants, particularly in geriatric and respiratory medicine may themselves be unusual and individually driven to create or move into these diversified roles.[10] Similarly too, in these specialties, they appeared at times to be unsupported by their collective profession and had to be very self-driven in terms of seeking education, supervision and development opportunities. Palliative medicine provided an interesting example of where community roles had been more formalised into career development and training. Yet, still even for consultants in this specialty, isolation could be a factor. Interestingly, the consultants we spoke to often consciously traded off this isolation with perceived freedom from organisational constraint. As these posts continue to develop, it will be important in future research to further understand consultants' professional roles and degree to which these may be compromised or strengthened by their location in the community and the impact this has on practice.

Although exploratory, our research suggests that the idiosyncratic nature of some of these posts and lack of clarity around roles may create challenges in the long term and, without any kind of 'blueprint' for how these posts should develop, there may be missed opportunities for learning and building on experience. There are benefits from these posts remaining relatively unbounded in terms of developing a more flexible workforce. Yet, greater formalisation or codification of these roles, for example by professional bodies, may help to overcome some of the challenges created by the lack of understanding, and to develop these posts as a targeted and desirable career choice for upcoming trainees. Recent research into the role of integrated respiratory specialists in the UK by the British Thoracic Society suggests that this has started to be taken on board by professional bodies. The research highlights similar findings in that integrated specialist roles are currently taken by passionate individuals, but that a lack of forward planning, job description and clear career pathways raises concerns going forward.[8]

There are a number of limitations to our study. It is exploratory in nature and points to areas for further investigation rather than providing definitive evidence. We are unsure how our sample of consultants may differ from the wider pool of community-based consultants in these specialties. Therefore, findings, such as the dependence on individual enthusiasm in creating and shaping posts, may be a function of our sample, although we deliberately sought to widen our study sample through the inclusion of consultants from three specialties. We also limited our study to understanding the perspective of consultants themselves and acknowledge that future research would benefit from understanding the perspectives of the wider workforce, including management, GPs and hospital-based specialists, as well as patients.

Conclusion

In seeking to understand the experience of community-based consultants, our study suggests while these posts are often driven or taken up by highly motivated individuals who report the benefits in terms of being able to provide more appropriate care for patients, the long-term development of these posts may be constrained by a number of factors. Their idiosyncratic nature, the lack of clarity around the role, challenges to professional identity and lack of training opportunities or continued professional development may all need to be considered. ■

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